

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044844

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11663

STATE FILE NUMBER

FILED DEC 14 1962

VS 300
Rev. 4/59

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240063

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. LouisLength of stay in lb
2 daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Lukes HospitalInside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

c. CITY OR TOWN University City

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
744 InterdriveReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

female

Cauc.

ab. 1889

ab. 73

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

12. CITIZEN OF WHAT COUNTRY

housewife

at home

USSR

USA

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

Malech (unk)

Riva

(unk)

Julius Shulman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

No

None

Jack Shulman

#5 Nob Hill

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Ventricular Fibrillation

Myocardial Infarction

Coronary Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

5 min

1 hour

20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Bronchial Asthma, Hypertension

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 1955 to Dec 1962 and last saw her alive on 12-4-62
Death occurred at 11:20P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

REGISTRAR'S SIGNATURE

Berger Memorial

4715 McPherson

DEC 5- 1962

Road Smith. M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3988

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.